(b) The budget report shall cover a 12-month period from January 1 to December 31 unless another time frame is specified by the commissioner.

(c) If a facility has undergone a change in its site specific certified capacity, the commissioner may, at his discretion, request the provider to submit a budget report subject to requirements listed in subsection (b)(1)(i)(b) and (b)(3)(iii).

(ii) Financial and Statistical Reports

(a) Each provider that operates a specialty hospital certified by OMRDD shall, on an annual basis, complete and file with the OMRDD and/or Blue Cross/Blue Shield of Greater New York, annual financial reports and related statistical information in the form and format supplied by the OMRDD and/or Blue Cross/Blue Shield of Greater New York.

(b) Such report shall cover a 12-month period from January 1 to December 31, unless another time frame is specified by the commissioner.

(c) Each such report shall be forwarded so that it is received no later than 120 days after the last day of the period which it covers, except as stated in Section (b)(4)(i) and (ii).

(d) If a facility has undergone a change in its site specific certified capacity, the commissioner may, at his discretion, request the facility to submit the incremental/decremental cost data associated with the capacity change. Such data shall comply with the requirements of Section (b)(3)(i).

(2) Statistical reporting requirements for specialty hospitals shall include but not be limited to the following:

(i) Each provider shall submit with its annual financial report, statistical data relevant to program utilization and in the form and format supplied by OMRDD or its agent, Blue Cross/Blue Shield of Greater New York. Such data shall include a roster of clients and their utilization review status for the financial reporting period in question, a listing of the actual number of client days for the specialty hospital and a

listing by client of the total number of days any client was on alternate care determination status as defined in Section (z)(3). This data will correspond to the identical time period of the financial report.

(ii) Each provider shall, upon the request of OMRDD, submit statistical data relevant to the administration and operation of the program as determined by the commissioner. Such data shall be submitted within the time frames specified in the request.

(3) Requirements for certification of financial reports and related statistical information.

(i) Each provider shall complete the required financial reports in accordance with generally accepted accounting principles, unless other principles are specified by this subpart or the Medicare Provider Reimbursement Manual, commonly referred to as HIM-15, published by the US Department of Health and Human Services Health Care Financing Administration (HCFA). The HIM-15 document is available from:

Health Care Financing Administration
Division of Communication Services
Production and Distribution Branch
Room 577, East High Rise Building
6325 Security Boulevard
Baltimore, Maryland 21207

(ii) The Medicare Provider Reimbursement Manual may be reviewed in person during regular business hours at the:

(a) NYS Department of State, 99 Washington Avenue, Albany, NY 12231; or by appointment at the

(b) NYS Office of Mental Retardation and Developmental Disabilities, Division of Revenue Management, 30 Russell Road, Albany, New York 12206-1377.

(iii) Financial reports information shall be certified for their compliance with Section (b)(3)(i) by the provider's executive director or officer and by an independent licensed public accountant or certified public accountant who is not on the staff of the provider, on the staff of a program operated by the provider, and who has no financial interest nor is an

affiliate in the program operated by the provider; and include a statement of the findings and opinion of the certified public accountant or licensed public accountant.

(iv) Budget reports shall be certified for their fair representation of anticipated expenditures by the provider's executive director or officer.

(4) Failure to file required financial and statistical reports

(i) The commissioner may grant an extension of time of up to 30 days for filing the required reports if OMRDD receives a written request for an extension from a provider, at least 15 days prior to the initial due date. Such request for extension shall document in writing that the provider cannot file the report by the due date for reasons beyond its control, and shall include an explanation of such reasons.

(ii) The commissioner may grant an additional extension of 30 days if the provider applies for an extension in accordance with the procedure stated in Section (b)(4)(i) above. The maximum allowable extension that may be granted will not exceed 60 days in total unless the commissioner, upon investigation, finds that failure to report is beyond the control of the provider and/or enforcement of the reporting time frame requirements would jeopardize the program's operation.

(iii) If a provider fails to file the require reports, on or before the due dates, taking into account any granted extensions, the commissioner may at his or her discretion reduce the specialty hospital's existing rate, exclusive of state paid items, by five percent for a period beginning on the first day of the month following the due date of the required reports and continuing until the last day of the calendar month in which the required information is received.

(iv) In the event that the rate for a specific rate period cannot be developed so that it will be effective on the first day of the rate period, due to the facility's not submitting the required reports by the due date, the rate in existence on the last day of the rate period (i.e., the length of time as determined by the commissioner that an approved rate is valid) prior to the subject rate period, will be in effect until such

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time as OMRDD can develop a new rate. The rate in existence on the last day of the rate period may be reduced by five percent according to the provisions of section(b)(4)(iii).

(v) When OMRDD develops a new rate for a specialty hospital for which a rate was paid in accordance with section(b)(4)(iv) above, the rate developed will be effective on the first day of the first month following receipt of the required reports. The commissioner may, at his discretion and based upon his finding that the factor(s) causing the delay has/have been corrected, make the rate retroactive to the beginning of the rate period in question if the provider makes such a request within 60 days subsequent to submission of the delinquent report.

(5) Requirements for the revision of financial reports shall include the following:

(i) In the event that OMRDD determines that the required financial report is incomplete, inaccurate, incorrect or otherwise unacceptable, the provider shall have 30 days from the date of its receipt of notification to submit revised financial reports or additional data. Such data or reports shall be certified by the provider's executive director or officer and an independent licensed public accountant or certified public accountant pursuant to the requirements stipulated in section(b)(3).

(ii) If the revised data referred to in section(b)(5)(i) is not received within 30 days of the provider's receipt of notification, the facility's existing rate may be reduced in accordance with section(b)(4)(iii) unless the commissioner has granted an extension pursuant to section(b)(4)(i) or (ii).

(iii) In the event the provider discovers that the financial reports it has submitted are incomplete, inaccurate, or incorrect prior to receiving its new rate, the provider must notify OMRDD that such error exists. The provider will have 30 days from the date such notification is received by OMRDD to submit revised reports or additional data. Such data or report shall meet the certification requirements of the report being corrected. If the corrected data or report is received within a reasonable time before the issuance of the

rate, OMRDD shall incorporate the corrected data or report into its computation of the rate without the provider having to file an appeal application.

(iv) If the revised data or report referred to in section(b)(5)(iii) is not received within the time periods set forth in section(b)(5)(iii) above, the facility's existing rate may be reduced in accordance with section(b)(4)(iii).

(c) Requirements of Financial Records

(1) Each provider shall maintain financial records which reflect all expenditures made and revenues received for its operations.

(2) Each provider shall complete and file with the New York State Department of Health and/or its agent, annual financial and statistical report forms supplied by the New York State Department of Health and/or its agent.

(3) The financial records shall include separate accounts for each type of expense and revenue included on the annual budget or annual cost report. Such sub-accounts and control accounts as are necessary for effective financial management may be established by the specialty hospital. A separate expense and revenue account shall be established to properly identify the expense and revenues directly and indirectly attributable to ACD clients.

(4) All such financial records and any related records shall be subject to audit by the commissioner or his agent, the Office of the State Comptroller, the State Department of Social Services and by agencies of the federal government as provided by law.

(d) Rate Setting

(1) A client day shall be the unit of measure denoting lodging and services rendered to one client between the census taking hours of the facility on two successive days; the day of admission but not the day of discharge shall be counted. One client day shall be counted if the client is discharged on the same day that the client is admitted, providing that there was an expectation that the admission would have at least a 24-hour duration.

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(2) For each facility the commissioner shall have established rates of reimbursement which are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities in order to provide care and service in conformity with applicable State and federal laws, regulations, and quality and safety standards.

(3) The rate period shall be from June 10, 1988 to December 31, 1988. Beginning January 1, 1989 and for every year thereafter, the rate period shall be from January 1 to December 31.

(4) Rate Calculation

(I) The rate for all non-ACD clients, and for ACD clients when the commissioner has determined that the occupancy of certified beds for the facility and the region is 80 percent or more (beds occupied by ACD clients shall not be counted as occupied beds), shall be determined as follows:

(*a*) For a newly certified facility, or any facility which has undergone a change of 20 percent or more in its site specific certified capacity and for which the commissioner has exercised his or her discretion according to section (b) (1) (I) (*c*), the reimbursable budget costs shall be divided by the higher of actual projected client days or calculated projected client days. Calculated projected client days shall be determined by multiplying the certified capacity, as listed on the provider agreement of the facility, by 365 days and by a utilization factor of 95 percent.

(*b*) For a facility other than the facilities covered in (*a*) above, the reimbursable actual costs shall be first trended to the rate year and then divided by the higher of either the actual reported client days, or the product of the certified capacity, as listed on the provider agreement, multiplied by 365 days and a utilization factor of 95 percent. The trend factor utilized shall be that figure developed by the New York State Department of Health based upon the price movement for voluntary operated, non-teaching hospitals located in New York City.

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(iii) There shall be no reimbursement for the following ACD clients:

(a) Those for whom the provider has not made the required showing with respect to an appropriate alternate care bed in accordance with its utilization review plan as required by section 680.9. An exception may be made if the provider has taken steps to transfer a client to an appropriate alternate care bed and a challenge as allowed in regulation has been made on behalf of the client.

(b) Those for whom the alternate care determination does not indicate that a Medicaid funded program is the appropriate level of care.

(5) Total reimbursable budget or actual operating costs utilized to calculate a rate shall be subject to [base-to-base] cost limitation principles as follows:

(i) Newly certified facilities

(a) Year 1 - Provider submits a budget. Rate is established from reimbursable budget costs and projected client days in accordance with section (d)(4)(i)(a).

(b) Year 2 - Year 1 reimbursable operating costs of the budget rate are trended with property costs added after trending.

(c) Year 3 - Rate is established as the lower of either:

(1) The reimbursable operating component of the actual costs, as defined in section (a)(5), for the Year 3 rate period trended to the rate period with the property costs added after trending, or

(2) The Year 2 rate, excluding property, trended with the property costs from the latest full year cost report added after trending.

(d) Year 4 - Rate is established as the lower of either:

(1) The reimbursable operating component of the actual costs, as defined in section (a)(5) for the Year 4 rate period trended to the rate period with the property costs added after trending, or

(2) The Year 3 rate, excluding property, trended with the property costs from the latest full year cost report added after trending.

(ii) Other than newly certified facilities

(a) Year 1 - Provider submits actual costs as defined in section (a)(5). A rate is established by trending the reimbursable operating costs and adding the property costs after trending.

(b) Year 2 - Rate is established as the lower of either:

(1) The reimbursable operating component of the actual cost, as defined in section (a)(5), for the Year 2 rate period trended to the rate period with the property costs added after trending, or

(2) The Year 1 rate excluding property, trended with the property costs from the latest full year cost report added after trending.

(c) Year 3 - Rate is established as the lower of either:

(1) The reimbursable operating component of the actual cost, as defined in section (a)(5), for the Year 3 rate period trended to the rate period with the property costs added after trending, or

(2) The Year 2 rate, excluding property, trended with the property costs from the latest full year cost report added after trending.

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(d) Year 4 - Rate is established at the lower of either:

(1) The reimbursable operating component of the actual cost, as defined in section (a) (5), for the Year 4 rate period trended to the rate period with the property costs added after trending, or

(2) The Year 3 rate, excluding property, trended with the property costs from the latest full year cost report added after trending.

(e) The [January 1, 1994 through December 31, 1994] rate shall be equal to the [trended] reimbursable operating costs and appeal adjustments contained in the Year 4 rate calculated pursuant to 5(i)(d) and trended in accordance with Section (d)(4)(i)(b) of this Part. Appropriately approved property shall be added to this amount. [The trend factor utilized shall be the same trend factor identified in (d)(4)(i)(b).]

(6) Payments attributable to a newly admitted client are subject to the commissioner's approval of that client's admission pursuant to section (b). Continued payments for each such client are subject to the facility's having obtained the approval of the commissioner on an annual basis for the retention of that client at the specialty hospital level of care.

(7) Reimbursement Offsets

If the costs of services not chargeable to the care of clients in accordance with 14 NYCRR as stated herein or HIM-15 are indeterminable and there is revenue derived therefrom, this revenue shall offset allowable cost.

(8) To be considered allowable, costs must be properly chargeable to necessary client care rendered in accordance with the requirements contained herein.

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(i) Except where specific rules concerning allowability of costs are stated herein, OMRDD shall use as its major determining factor in deciding on the allowability of costs, the Medicare Provider Reimbursement Manual (HIM-15).

See section (b)(3)(i). Where specific rules stated herein or in HIM-15 are silent concerning the allowability of costs, the commissioner shall determine allowability of costs based on reasonableness and relationship to client care and generally accepted accounting principles.

(ii) A monetary value assigned to services provided by a religious order and for services rendered by an owner and operator of a facility shall be considered allowable subject to review by OMRDD for reasonableness.

(iii) As determined by the commissioner, expenses or portions of expenses reported by an individual facility that are not reasonably related to the efficient and economical provision of care in accordance with the requirements contained herein because of either the nature or amount of the item, shall not be allowed.

(iv) As determined by the commissioner, costs which principally afford diversion, entertainment or amusement to owners, operators or employees of the facility shall not be allowed.

(v) As determined by the commissioner, costs for any interest expense related to funding expenses in excess of a facility's approved reimbursement rate, except as provided for in section (d)(8)(xii) or for any penalty imposed by governmental agencies or courts or for the costs of insurance policies obtained solely to insure against such penalty shall not be allowed. OMRDD will not pay interest on the final dollar settlement resulting from the retrospective impact of rate appeals. OMRDD will not reimburse interest expense incurred to meet funded depreciation requirements, pursuant to section (d)(10).

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